Form Review Checklist – Individual and Small Group Health Insurance (nongrandfathered - 2014)
Updated: May 22, 2013

Company Name:	
Product Name:	
Plan:	
☐	60% AV (Bronze)
☐	70% AV (Silver)
☐	80% (Gold)
☐	90% (Platinum)
☐	Child-only
☐	Catastrophic Plan (no minimum AV requirement, only available to individuals under age 30 or those with hardship/affordability exemption)
☐	Stand Alone Dental Plan

YES: Check this box if all contract provisions in the section meet minimum requirements.

NO: Check this box if any of the contract provisions do not meet minimum requirements, restrict coverage in a way not allowed by law, or for any other reason are inconsistent with the law.

N/A: Check this box if a contract does not have to meet this requirement (e.g., does not use Primary Care Physicians and therefore does not have to include designation of PCP option).

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
☐ **No pre-existing condition exclusions for child under age 19** ☐ **No pre-existing condition exclusions** ☐ "Pre-existing condition exclusion" means a limitation or exclusion on benefits based on the fact that the condition was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was received before that day. ☐ A pre-existing condition exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or date of denial).	PHSA §2704 PHSA §1255 (75 Fed Reg 37188, 45 CFR §147.108)	Attachment: Examples from federal regulations	☐	☐	☐
Explanation:					

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☐ **No lifetime limits on the dollar value of Essential Health Benefits (EHB):** ☐ Ambulatory patient services ☐ Emergency services ☐ Hospitalization ☐ Maternity and newborn care ☐ Mental health and substance use disorder services, including behavioral health treatment ☐ Prescription drugs ☐ Rehabilitative and habilitative services and devices ☐ Laboratory services ☐ Preventive and wellness services and chronic disease management ☐ Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply. Tip: Check benefit maximums and service limitations to ensure no dollar limits for EHBs. Problematic contract language/example: EHB-eligible hospital services limited to $100,000. This violates the prohibition on lifetime limits on EHB.	☐	☐	☐
Explanation:					
☐ **No annual limits on the dollar value of EHB:** ☐ Ambulatory patient services ☐ Emergency services ☐ Hospitalization ☐ Maternity and newborn care ☐ Mental health and substance use disorder services, including behavioral health treatment ☐ Prescription drugs ☐ Rehabilitative and habilitative services and devices ☐ Laboratory services ☐ Preventive and wellness services and chronic disease management ☐ Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	Tip: If there are maximum dollar limits, check to ensure that these are not for benefits within one of the EHB categories. Problematic contract language/example: EHB-eligible hospital services limited to $100,000 annually. This violates prohibition on annual dollar limits on EHB.	☐	☐	☐
Explanation:					
☐ **No rescissions except in cases of fraud or intentional misrepresentation of material fact**	PHSA§2712 (75 Fed Reg 37188,	Tip: Look for insurer's right to cancel to ensure that in a case of retroactive cancellation, the only conditions listed in the contract are fraud or intentional	☐	☐	☐

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☐ Rescission is a cancellation of coverage that has retroactive effect. It includes a cancellation that voids benefits paid . ☐ Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected.	45 CFR §147.128)	misrepresentation of material fact. Attachment: Examples from federal regulations			
Explanation:					
☐ **Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance.** ☐ Covered preventive services include: • Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the USPSTF; • Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (CDC); • Evidence-informed preventive care and screenings provided for in HRSA guidelines for infants, children, adolescents, and women; and • Current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention (do not include recommendations issued in or around Nov. 2009). ☐ Coverage without cost-sharing (deductibles, co-payments, co-insurance)	PHSA §2713 (75 Fed Reg 41726, 45 CFR §147.130) Mammography: NE 44-785 Diabetes: NE 44-790 Colorectal Screening: 44-7,102 Child immunization: 44-784	Note: Issuers must make changes to coverage & cost-sharing based on new recommendations/guidelines for the first policy year beginning on or after the date that is one year after the new recommendation/guideline went into effect. Note: Network plans may have cost-sharing for preventive benefits when out-of network providers are used. An issuer does not have to cover items/services if removed from guidelines. Issuers may use reasonable medical management techniques to determine frequency, method, treatment, or setting for USPSTF recommendations if not specified by the USPSTF. Tip: If a policy has co-pays, co-insurance, deductibles or other cost-sharing, look for language that exempts preventive benefits from those cost-sharing provisions. Look for exclusionary language for any of the preventive benefits. Issuers may have cost-sharing for office visits. Examples of allowed and not allowed cost sharing: • preventive service is billed separately from an office visit – cost-sharing ok for the office visit; • preventive service is the primary purpose of the office visit and is not billed separately from the	☐	☐	☐

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
		office visit – cost-sharing may not be imposed; • preventive service is provided but is not the primary purpose of the office visit and is not billed separately – cost-sharing ok for the office visit. Issuers must provide 60 days advance notice, generally, to enrollees before the effective date of any material modification and this includes changes in preventive benefits. An issuer may provide or deny coverage for items and services in addition to the defined preventive services. An issuer may impose cost-sharing requirements for a treatment not included in the defined preventive services, even if the treatment results from an item or service described as a preventive service. Attachment: Examples from federal regulations			
Explanation:					
☐ **Provide 60 days advance notice to enrollees before the effective date of any material modification including changes in preventive benefits.**	PHSA 2715 (75 Fed Reg 41760)		☐	☐	☐
Explanation:					
☐ **Coverage for dependents must be available up to age 26 if policy offers dependent coverage.** ☐ Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: • financial dependency on primary subscriber, • residency, • student status, • employment,	PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)	Impermissible restriction example: Adult child can stay on parent's coverage only if child spends at least 6 months in the state. Issuers are not required to cover the child of a child dependent. Attachment: Examples from federal regulations	☐	☐	☐

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• eligibility for other coverage, • marital status. ☐ Terms of the policy for dependent coverage cannot vary based on the age of a child.					
Explanation:					
☐ **Provides Essential Health Benefits –** ☐ **Form reviewer: complete EHB form review**	PHSA §2707		☐	☐	☐
☐ **Coverage for emergency services required (See EHB above) and:** ☐ Cannot require prior authorization; ☐ Cannot be limited to only services and care at participating providers; ☐ Must be covered at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider); ☐ Must pay for out-of-network emergency services the greatest of: (1) The median in-network rate; (2) the usual customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for out-of-network services); or (3) the Medicare rate. ☐ "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity that a person would reasonably expect the absence of immediate medical attention to result in a condition that places the health of the individual in serious jeopardy, would result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman having contractions, that there is inadequate time to safely transfer the woman to another hospital for delivery or that a transfer may pose a threat to the health or safety of the woman or the unborn child. ☐ "Emergency medical services" means a medical screening	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138) SSA §1395dd	Note: for pre-2014 non-grandfathered policies, this requirement only applies if policy covers emergency services. Cost-sharing requirements that apply generally to out-of-network benefits may be imposed on out-of-network emergency services. Attachment: Examples from federal regulations	☐	☐	☐

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examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department to evaluate the condition; and within the capabilities of the staff/facilities available at the hospital, examination/ treatment required to stabilize the patient. ☐ "Stabilize" means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.					
Explanation:					
☐ **For network plans requiring a primary care provider to be designated and requiring referrals:** ☐ allow each enrollee to designate any participating primary care provider who is available to accept such individual ☐ a physician specializing in pediatrics may be designated as PCP ☐ no referral required for services from in-network OB/GYNs ☐ Notice of these is required when issuer provides primary subscriber with a policy, certificate, or contract of health insurance.	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138) OBGYN: NE 44-786	Attachments: • Model Notice of Right to Designate a Primary Care Provider • Model Notice of Right to Designate a Primary Care Provider (addition for pediatrician) • Model Notice of Right to Receive Services from an OB/GYN without a referral	☐	☐	☐
Explanation:					
☐ **Maternity coverage (see EHB) and required benefits for hospital stays in connection with childbirth:** ☐ Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ☐ EXCEPTION: this does not apply if the provider, in consultation with the mother, decides to discharge the mother or the newborn prior to the minimum length of stay. ☐ No prior authorization required for 48/96 hour hospital stay	PHSA §2725 (45 CFR §148.170)	Note: for non-grandfathered policies pre-2014, this applies only if maternity is a covered benefit. In 2014, maternity must be covered as one of the Essential Health Benefits. Note: in the case of multiple births, hospital length of stay begins at the time of the last delivery. Attachments: • Model Newborns' Act Disclosure	☐	☐	☐

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☐ Hospital length of stay begins at the time of delivery if delivery occurs in a hospital and at time of admission in connection with childbirth if delivery occurs outside the hospital. The issuer is not allowed to: ☐ Deny the mother/newborn eligibility, continued eligibility, to enroll or to renew coverage to avoid these requirements; ☐ Provide monetary payments/rebates to encourage mothers to accept less than the minimum requirements; ☐ Penalize an attending provider who provides services in accordance with these requirements; ☐ Provide incentives to an attending provider to induce the provider to provide care inconsistent with these requirements; ☐ Restrict benefits for any portion of a period within the 48/96-hour stay in a manner less favorable than the benefits provided for any preceding portion of such stay; ☐ Require the mother to give birth in a hospital; ☐ Require the mother to stay in the hospital for a fixed period of time following the birth of her child. ☐ *An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother.*		Model Newborn Act Newborn from Birth Coverage NE 44-710.19 Adopted Children Coverage NE 44-799			
Explanation:					
☐ **Parity in Mental Health and Substance Use Disorder Benefits**	PHSA §2726	PLACEHOLDER	☐	☐	☐
☐ **Coverage for reconstructive surgery after mastectomy (Women's Health and Cancer Rights Act)** ☐ If covers mastectomy, then must also cover reconstructive	PHSA §2727	Tip: Look for exclusions for cosmetic surgery and make sure it is clear that reconstructive surgery for mastectomy is NOT considered cosmetic and therefore excluded.	☐	☐	☐

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surgery in a manner determined in consultation with provider and patient. Coverage must include: ☐ Reconstruction of the breast on which the mastectomy was performed (all stages); ☐ Surgery and reconstruction of the other breast to produce symmetrical appearance; ☐ Prostheses; and ☐ Treatment of physical complications at all stages of mastectomy. ☐ This benefit can be subject to annual deductibles and coinsurance provisions if consistent with those established for other medical/surgical benefits under the coverage. ☐ The issuer is prohibited from denying a patient eligibility to enroll or renew coverage solely to avoid these requirements; penalizing or offering incentives to an attending provider to induce the provider to furnish care inconsistent with these requirements. ☐ Notice about the availability of mastectomy-related benefits must be given at issue and annually.		Tip: Look for limitations for only cancer patient/diagnosis of cancer before benefit kicks in. (Statute does not limit mastectomy to cancer diagnosis). Attachment: • Model WHCRA Enrollment Notice • Model WHCRA Annual Notice			
Explanation:					
☐ **Coverage for dependent student on <u>medically necessary leave of absence</u> ("Michelle's Law")** ☐ Issuer cannot terminate coverage due to a medically necessary leave of absence before: • The date that is 1 year after the first day of the leave; or • The date on which coverage would otherwise terminate under the terms of the coverage. ☐ Change in benefits prohibited – child on medically necessary leave of absence is entitled to the same benefits as if the child continued to be a covered student who was not on a	PHSA §2728 (45 CFR §147.145) NE 44-797	Note: ACA requires issuers to provide dependent coverage to age 26 regardless of student status. Under some circumstances, an issuer may provide dependent coverage beyond age 26, in which case these provisions would apply. The issuer can require receipt of written certification by a treating physician of the dependent child that states that the dependent is suffering from a serious illness or injury and that the leave of absence is medically necessary.	☐	☐	☐

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medically necessary leave of absence; however, if there is a change in the manner in which the beneficiary/parent is covered and continues to cover the dependent, the changed coverage will apply for the remainder of the period of the medically necessary leave of absence. ☐ Eligibility for protections: a dependent child under the terms of the coverage of the beneficiary, enrolled in the coverage on the basis of being a student immediately before the first day of the medically necessary leave of absence involved. ☐ "Medically necessary leave of absence" means: a leave of absence or change of enrollment of a dependent child from a post-secondary education institution that: 1. Commences while the child is suffering from a serious illness or injury; 2. Is medically necessary; and 3. Causes the child to lose student status for purposes of coverage under the terms of coverage. ☐ Issuer must include with any notice regarding a requirement for certification of student status for coverage, a description of the terms for continued coverage during medically necessary leaves of absence.					
Explanation:					
☐ **Coverage is guaranteed renewable** ☐ May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	PHSA §2702 (45 CFR §148.122)	Tip: Renewability statements that include other reasons for not renewing are not permissible.	☐	☐	☐
Explanation:					
☐ **Coverage is not based on <u>genetic information (GINA)</u>** An issuer is not allowed to:	PHSA §2753 (74 Fed Reg 51664,	Tip: A test to determine whether an individual has a BRCA1 or BRCA2, genetic variants associated with a significantly increased risk for breast cancer, is a	☐	☐	☐

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☐ Adjust premiums based on genetic information; ☐ Request /require genetic testing; ☐ Collect genetic information from an individual prior to/in connection with enrollment in a plan, or at any time for underwriting purposes. EXCEPTION FOR MEDICAL APPROPRIATENESS (only if the individual seeks a benefit under the plan): ☐ If an individual seeks a benefit under a plan, the issuer may limit or exclude the benefit based on whether the benefit is medically appropriate and the determination of whether the benefit is medically appropriate is not for underwriting purposes. ☐ If a plan conditions a benefit on medical appropriateness, and medical appropriateness depends on the genetic information of an individual, the plan can condition the benefit on genetic information (the issuer is permitted to request only the minimum amount of genetic information necessary to determine medical appropriateness). ☐ The incidental collection of genetic information is permitted, as long as it is not used for underwriting purposes. EXCEPTIONS: ☐ A health care professional who is providing health care services to an individual can request that the individual undergo a genetic test. ☐ An issuer can obtain and use results of a genetic test for making a determination regarding payment (minimum amount of information necessary to make the determination). ☐ An issuer may request but not require that a beneficiary undergo a genetic test if the request is pursuant to research and the following conditions are met: ☐ Research must be in accordance with Federal regulations and applicable state/local law or regulations; ☐ The issuer makes a written request, and the request clearly	45 CFR §148.180)	genetic test. An HIV test, complete blood count, cholesterol test, liver function test, or test for the presence of alcohol or drugs is not a genetic test. Attachment: Examples from federal regulations			

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indicates that compliance is voluntary, and noncompliance will have no effect on eligibility for benefits; ☐ No information collected can be used for underwriting purposes; ☐ The issuer completes a copy of the "Notice of Research Exception under the Genetic Information Nondiscrimination Act" ☐ "Genetic information" is information about an individual's/family members' genetic tests, the manifestation of a disease or disorder in family members of the individual, or any request for or receipt of genetic services, or participation in clinical research that includes genetic services by the individual/family member. • With respect to a pregnant woman, genetic information includes information about the fetus. • With respect to an individual using assisted reproductive technology, genetic information includes information about the embryo. • Genetic information does NOT include information about the sex or age of any individual. ☐ "Manifestation" means that an individual has been or could reasonably be diagnosed with a disease, disorder, or pathological condition; not manifested if the diagnosis is based principally on genetic information. ☐ "Genetic services" means a genetic test, genetic counseling or genetic education. ☐ "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, if the analysis detects genotypes, mutations, or chromosomal changes. A genetic test does not include an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition.					

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☐ "Underwriting purposes" means: • Rules for determination of eligibility for benefits under the coverage; • The computation of premium or contribution amounts under the coverage; • The application of any pre-existing condition exclusion under the coverage (until 2014); and • Other activities related to the creation, renewal, or replacement of a contract of health insurance.					
Explanation:					
☐ **Providers operating within their scope of practice cannot be discriminated against** ☐ Issuers may not discriminate against any provider operating within their scope of practice.	PHSA§2706	Tip: Check to ensure that if a service /treatment is covered that there are no limitations on licensed providers who can provide that service. Also providers cannot charge for services provided to immediate family as defined by statute.	☐	☐	☐
Explanation:					
☐ **Coverage for individuals participating in approved clinical trials:** ☐ Issuer must cover "routine patient costs" – items and services consistent with benefits for typically covered services. ☐ If an in-network provider is participating in a clinical trial, the issuer may require participation in the trial through the participating provider if the provider will accept the individual as a participant. ☐ An individual may participate in an approved clinical trial conducted outside the state in which the individual resides. ☐ "Qualified individual" – eligible to participate according to trial protocol and referring health care professional/ medical information establishing appropriateness.	PHSA §2709		☐	☐	☐

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☐"Approved clinical trial" – phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as outlined in PHSA 2709					
Explanation:					
Special enrollment period	*further guidance needed*		☐	☐	☐
Open enrollment period(s) required [If no state standard, issuers may determine the number and length of open enrollment periods.]	*further guidance needed*		☐	☐	☐
☐ **Minimum 60% actuarial value is required for individual coverage.** ☐ Individual policies must meet the AVs in the metal tiers. ☐ *Reviewer check*: included printout of AV calculator and methodology. ☐ *Reviewer check*: included disclosure of how benefits were defined and entered into AV calculator.	ACA §1302	AV is measured as a percentage of expected health care costs a health plan will cover; calculated based on the cost-sharing provisions for a set of benefits.	☐	☐	☐
Explanation:					
☐ **Claims procedures, including applicable time frames** ☐ **General requirements:** ☐ required to include a description of: o claims procedures, o procedures for obtaining prior approval, o preauthorization procedures, o utilization review procedures, and o applicable time frames ☐ The claims procedure cannot unduly inhibit the initiation or processing of claims.	45 CFR §147.136; 29 CFR § 2560.503-1 Claims Procedures Required: NE 44-710.03 Claims Procedures Permissive: NE 44-710.04	Tip: If the issuer requires payment of a fee or costs as a condition to making a claim or to appealing an adverse benefit determination, it is considered to unduly inhibit the initiation and processing of claims. Tip: Check for any additional criteria in the contract that a patient must meet before being allowed to submit claims and for asking for review of claims to ensure that the procedure does not unduly inhibit initiation or processing of claims. An authorized representative of the claimant may act on behalf of the claimant in pursuing a benefit claim or appeal of an adverse benefit determination.			

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☐ A "claim for benefits" is a request for benefits made by a claimant in accordance with an issuer's reasonable procedure for filing benefit claims, including pre-service and post-service claims. ☐ **Time and process for urgent care (pre-service, post-service):** ☐ Determination for urgent care made within 72 hours. ☐ Notice of the determination within 72 hours of receipt of the claim. ☐ Notice of urgent care decisions include a description of the expedited review process applicable to such claim. ☐ No extension of the determination time-frame is permitted. ☐ If the claimant fails to provide sufficient information, issuer must notify the claimant within 24 hours and must include specific information necessary to complete the claim. ☐ The claimant must have at least 48 hours to provide the specified information. ☐ A determination must be made within 48 hours of receiving specified information or expiration of time afforded to the claimant to provide the specified information (whichever is earlier). ☐ **Time and process for concurrent urgent care (at the request of the claimant):** ☐ Claim for concurrent urgent care: if a claimant requests to extend the course of treatment beyond time/number of treatments. ☐ Claim must be made at least 24 hours prior to the expiration of the prescribed period of time/number of treatments. ☐ Determination must be made within 24 hours. ☐ Notification is required within 24 hours of the claim's		Attachment: • Model Notice of Adverse Benefit Determination Review Title 210 NAC Chapter 61			

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request ☐ **Time and process for pre-service claim:** ☐ Determination for a pre-service claim must be made within 15 days of the request of the claim. ☐ Notice of the determination within 15 days of the claim. ☐ Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer. ☐ Notice required of the extension prior to the expiration of the initial 15-day period, ☐ The issuer must identify for the claimant the circumstances requiring the extension and date by which the issuer expects to render a decision. ☐ If the claimant fails to provide sufficient information, the issuer must notify the claimant and specifically describe the required information needed to render a decision. ☐ Claimant has 45 days from receipt of notice of insufficient information to provide specified information. ☐ **Time and process for on-going services/treatment (concurrent care decisions):** ☐ Reduction/termination of benefits of ongoing courses of treatment (concurrent care) before the end of the time/treatments is considered an adverse benefit determination. ☐ Determination for concurrent care must be made sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination. ☐ Notice of the determination sufficiently in advance of the reduction/termination of benefits to allow the claimant to appeal and obtain a determination on the review of the adverse benefit determination BEFORE reduction/termination.					

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☐ **Time and process for post-service claim:** ☐ Determination for post-service claim must be made within 30 days of receipt of claim. ☐ Notice of the determination within 30 days of receipt of the claim. ☐ Determination extension up to 15 days allowed if necessary due to matters beyond the control of the issuer: ☐ Notice of the extension must be provided to the claimant prior to expiration of the initial 30-day period, ☐ The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision. ☐ If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information necessary to render a decision. ☐ The claimant has at least 45 days from the receipt of notice to provide the specified information. AS OUTLINED IN THE PROMPT PAY ACT NE 44-8004 ☐ **Standards for all required notices:** ☐ Issuer must provide the claimant with written or electronic notification of any adverse benefit determination for pre-service, post-service, and concurrent treatment claims. ☐ All notices of adverse benefit determination (including final internal adverse benefit determinations) must be provided in a culturally and linguistically appropriate manner and must include: ☐ Information sufficient to identify the claim involved including date of service, health care provider, and, upon request, diagnosis/treatment codes and their meanings;					

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☐ Specific reason for the adverse determination, including the denial code and its corresponding meaning and a description of the issuer's standard that was used in denying the claim; ☐ A final internal adverse benefit decision must include: ☐ a discussion of the decision; ☐ a description of available internal appeals and external review processes; ☐ a description of how to initiate an appeal. ☐ An adverse benefit determination must describe: ☐ applicable expedited review process, ☐ availability of and contact information for health insurance consumer assistance or ombudsman.					
Explanation:					
☐ **Internal appeals of adverse benefit determinations - processes, rights and required notices:** ☐ Enrollees have a right to appeal an adverse benefit determination. ☐ Enrollees may review the claim file and present evidence and testimony as part of the internal appeals process. ☐ Enrollees have at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal. ☐ Enrollees must have access to an expedited review process. ☐ Requests for expedited review must be allowed to be submitted orally or in writing. ☐ Pre-service claim: ☐ Determination must be made within 15 days after receipt of the claimant's request. ☐ Notice of the determination within 30 days after receipt of the claimant's request.	PHSA §2719 (75 Fed Reg 43330; 76 Fed Reg 37208, 45 CFR §147.136) NE Grievance Procedures: NE 44-7304-7315	Attachment: • Model Notice of Final Internal Adverse Benefit Determination Through LB 147 Nebraska adopted the NAIC External Review model law.			

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☐ Post-service claim: ☐ Determination must be made within 15 days after receipt of the claimant's request. ☐ Notice of the determination within 60 days after receipt of the claimant's request. ☐ Urgent claim: ☐ Determination must be made within 72 hours after receipt of the claimant's request. ☐ Notice of the determination within 72 hours after receipt of the claimant's request. ☐ If claimant fails to provide sufficient information to determine covered/payable benefits for an urgent claim, the issuer must: ☐ Notify the claimant within 24 hours of the information necessary to complete the claim. ☐ Give the claimant at least 48 hours to provide the specified information. ☐ Provide notice of the determination within 48 hours of the earlier of receiving the specified information and the end of the time period provided to return the specified information. ☐ The issuer must provide the claimant with written or electronic notice of the determination in a culturally and linguistically appropriate manner. ☐ In the case of an adverse benefit determination, the notification shall include: ☐ Information sufficient to identify the claim involved (including date of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);					

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☐ Diagnosis/treatment codes and meanings must be provided as soon as practicable. Requests for this information cannot be considered a request for an internal appeal or external review. ☐ Specific reason(s) for the determination, including the denial code and corresponding meaning, as well as a description of issuer's standard that was used in denying the claim (including a discussion of the decision in final internal adverse benefit determination). ☐ Description of available internal appeals and external review processes. ☐ Information on how to initiate an appeal. ☐ Information about the availability of, and contact information for, office of health insurance consumer assistance or ombudsman. ☐ A statement that the claimant is entitled to receive reasonable access to/copies of all documents, records, and other information relevant to the claim. ☐ An *adverse benefit determination* means a denial, reductions, or termination of, or failure to provide or make payment for a benefit, including denial, reductions, or termination of, or failure to provide or make payment based on a determination of beneficiary's eligibility to participate in a plan, and including denial, reductions, or termination of, or failure to provide or make payment for a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. ☐ A rescission of coverage must be treated as an adverse benefit determination. ☐ If an issuer fails to adhere to all of the requirements listed with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process and may initiate an					

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external review or any remedies available under state law. ☐ The internal claims and appeals process will not be deemed exhausted if the violation did not cause harm to the claimant so long as the issuer demonstrates that the violation was for good cause or due to matters beyond the control of the issuer, and ☐ That the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the claimant. ☐ Ongoing (concurrent care) decisions: ☐ Issuer is required to provide continued coverage pending the outcome of an appeal; ☐ must provide benefits for an ongoing course of treatment; and ☐ cannot reduce or terminate benefits. ☐ Provide advance notice and an opportunity for a review in advance of reducing or terminating benefits.					
Explanation:					
☐ **External review processes rights and required notices:** ☐ External review of an adverse benefit determination for: ☐ medical necessity; ☐ appropriateness; ☐ health care setting; ☐ level of care; ☐ effectiveness of a covered benefit; and ☐ rescission. ☐ External review of adverse benefit determinations for experimental or investigational treatments or services. ☐ Have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. ☐ Issuers must provide effective written notice to claimants of	PHSA §2719 (75 Fed Reg 43330; 76 Fed Reg 37208, 45 CFR §147.136)	Tip: If there is a filing fee, it cannot be more than $25. Attachment: • Model Notice of Final External Review Decision • Through LB 147 Nebraska adopted the NAIC External Review Model Law			

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external review rights in plan materials, and in each notice of adverse benefit determination. ☐ If exhaustion of internal appeals is required prior to external review, requirement to exhaust does not apply if: ☐ issuer did not meet internal appeal process timelines (with limited exceptions); ☐ in cases of urgent care. ☐ Cost of an external review must be borne by the issuer. ☐ Claimant cannot be charted a filing fee greater than $25. ☐ Restriction on the minimum dollar amount of a claim is not allowed. ☐ Claimant must have at least 120 days to file for external review after the receipt of the notice of adverse benefit determination (including final internal adverse benefit determination). ☐ IRO decision is binding on the issuer. ☐ For standard reviews (not urgent), the IRO must inform the issuer and the claimant in writing of its decision within 45 days from receipt of the request for review. ☐ **Urgent care:** ☐ The process must provide for expedited external review of urgent care claims. ☐ The IRO must inform the issuer and the claimant of an urgent care decision within 4 business days from receipt of the request for review. ☐ If the IRO's decision was given orally, the IRO must provide written notice of the decision within 48 hours of the oral notification.					
Explanation:					

*** OF NOTE SUMMARY OF BENEFITS AND COVERAGE MUST BE PRESENTED FOR EACH PLAN FILED IN NEBRASKA

ALL MARKETING MATERIALS SHOULD ALSO BE FILED TO ENSURE THE REQUIREMENTS OF THE ACA ARE MET.